# THREE ISSUES IN ADDICTIONS




***BEST ADVICE***

ARF
Addiction Research Foundation
Fondation de la recherche sur la toxicomanie

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**Chapter 1**

# The Path of Least Resistance: the trend to normalize alcohol

Recently, news reports have carried a variety of stories concerning alcohol and the way it is marketed and consumed in Ontario and Canada. These reports have covered proposals for selling beer and wine in corner stores, challenges to CRTC restrictions on the advertising of hard liquor and the partnership between a large grocery chain and a wine maker to set up a store within a store. We've also seen news of free trade agreements and GATT decisions calling for equitable access to Canadian markets for foreign producers, reports of pilot projects allowing the use of credit cards to pay for alcohol purchases, and announcements of the licensing of stadiums and sponsorship of sporting and cultural events by breweries, wineries and distillers.

The stories at first seem disparate, appearing as scattered points on a page headlined "alcohol." But in fact the points are connected by the thread of a single question: Should we treat alcohol as if it were just another product, not all that different from cheese or bed linens, or is alcohol somehow different and deserving of special regulation and consid-

eration? If we fail to respond to these stories in the context of that underlying question, we risk a haphazard, patchwork alcohol policy. And we miss the opportunity to weave a balanced and logical approach to alcohol in our society based on concerns for public health and safety, the convenience of consumers and the interests of producers.

## Alcohol Controls: Protecting Public Health

***Alcohol Monopolies*** From the time of their emergence in Sweden in the mid-nineteenth century, modern government alcohol monopolies, including government-run retail stores, have been recognized as a way to promote public health and order. Government monopolies spread widely through Scandinavia and the English-speaking world in the years before the First World War, and following the Prohibition era in North America, all Canadian provinces and 18 U.S. states created alcohol monopolies. Today, full or partial alcohol monopolies also exist in Sweden, Finland, Norway, Iceland, Turkey and New Zealand as well as numerous developing and Eastern European countries.

In setting up alcohol monopolies, governments around the world recognized that because of the risks to public health, alcohol could not be treated

as just another consumable product. Perhaps as important, governments recognized their vital role in advocating the responsible use of alcohol and in balancing concern for public health against the desires of consumers and the needs of alcohol producers.

***Price Policies*** Traditionally, governments have raised revenues through the taxation of alcohol. But, as well as being a source of revenue, taxes on alcohol have an important public health function. Over the decades, as our knowledge of alcohol and its impact has grown, we have come to realize that alcohol's risks are not associated solely with heavy drinking. Even low or moderate levels of use can impair worker safety, increase risks of certain cancers and, during pregnancy, affect the development of the fetus. And recent research has indicated that there is a relationship between overall alcohol use and rates of health problems. As a result, there has been a growing interest throughout the world in the use of alcohol controls such as tax increases to reduce alcohol-related problems. (see ARF Best Advice, "Alcohol and Tobacco Taxes: A Public Health Priority")

## Pressures for Reduced Controls

***Trade Liberalization*** Moves at the international level to remove trade barriers through free trade agreements and the General Agreement on Tariffs and Trade (GATT) also contribute to pressures to liberalize the availability of alcohol. In Ontario, discussions have focussed on charges by American brewers that Canada discriminates unfairly against their products in the Canadian market. Another apparent inequity is that Ontario winemakers are allowed to sell their products in "brand" stores, while foreign winemakers are restricted to selling only through LCBO outlets. Under free trade, the tendency is for inequities of this nature to be undone by liberalizing market opportunities for foreign producers rather than by further restricting domestic producers. Often, the effect of a less-restricted market on public health goes virtually unnoticed in the debate.

***Self-control and Alcohol Controls*** At the same time, pressure has increased for the individual to exhibit self-control when it comes to drinking. We are far less tolerant of drinking and driving than ever before, and our perception of a good host has shifted from one who offers "one more for the road" to one who offers to call a taxi for an impaired guest.

But there is another side to the promotion of individual responsibility. In recent years, market forces have pushed to widen the availability of alcohol. "Let the consumer decide!" they argue. If the individual is responsible for saying "No" to inappropriate alcohol use, the argument goes, then the individual should also be qualified to determine when that use is appropriate.

## Normalization: Seeing the Whole Picture

Like taxes on cigarettes which drive down the number of smokers and like legislation which makes it illegal to serve alcohol to someone who is intoxicated, decisions about alcohol distribution and pricing will affect public health. However, when these decisions are presented in isolation, the potential effects may be difficult to pin down. Will the sale of beer at a hockey game increase consumption to the point of increasing social and health care costs? Will the opening of wine "boutiques" in half a dozen grocery stores do the same? What about advertising hard liquor on television or selling beer and wine in corner stores?

Examined separately, each decision may have only a small impact on alcohol consumption levels, but the sum of those decisions may in fact be

greater than the parts. Each has the potential to push us a step further along the continuum towards normalizing alcohol – treating it like cheese or bed linen – and the momentum created by each additional step may magnify the subsequent effects. It has been estimated that, today, alcohol use costs the province of Ontario $4.3 billion per year in health care, lost wages and other social costs. Changes that normalize alcohol and increase its consumption tend to increase associated social and health care costs correspondingly.

And the fact remains that while our society has embraced the idea of individual responsibility when it comes to alcohol consumption, government still has a role to play in fostering an atmosphere which encourages responsible consumption. A recent survey of the attitudes of Ontario residents toward alcohol policy found that, on the whole, respondents tended to support existing or more stringent alcohol policies. Saying "yes" to individual responsibility does not rule out saying "yes" to government intervention in support of that responsibility.

## Policy Decisions:
## Weaving a Balanced Approach

Alcohol policy options cannot be adequately assessed in isolation from each other or from the societal context in which they will be implemented. Each decision must be based on an examination of how it will affect consumption rates and, correspondingly, the social and health costs of that consumption. The interaction of policy decisions must also be recognized, bearing in mind that decisions have the potential either to reinforce or to reshape our attitude toward alcohol use.

It is essential that alcohol monopolies and other control agencies co-operate with and consult health agencies in assessing the public health impact of decisions concerning alcohol availability. Whereas a monopoly may be balancing the competing needs of public health, industry concerns and consumer preferences, health agencies are able to act as a clear advocate in one area. As well, health agencies may be best suited to view public health concerns across a range of separate issues.

A balanced approach to alcohol policy will view the consumer's convenience and commercial interests in the context of a broader responsibility to protect the public health. It is this yardstick against which alcohol policy options must be measured.

## Recommendations

In assessing alcohol policy decisions, the Addiction Research Foundation recommends that:

• Safeguarding public health should be a primary goal of government policy. All alcohol-related issues, including those involving international trade, domestic production and the generation of government revenue by monopolies, should be assessed first and most importantly according to their impact on public health.

• Alcohol policy development, while recognizing that alcohol can be used responsibly, should have as its goal the reduction of alcohol-related harm. As a minimum standard, alcohol policy decisions should have a neutral impact on public health, and where possible, a positive effect is desirable.

• Controlling the availability of alcohol, both through taxes and through limits on the outlets and conditions of sale, should continue to be recognized as an important policy tool for minimizing alcohol-related harm.

**Chapter 2**

# Abstinence and Reduced Drinking: two approaches to alcohol treatment

While approaches and philosophies may differ, all who are involved in addictions treatment and prevention are travelling toward a common destination: the reduction of the harm caused by inappropriate drinking. But as with all journeys, there have been disagreements over which route to take, and whether there may in fact be more than one road leading in the same direction.

Much of the work in the field of addictions treatment has been done in the last 30 to 40 years, and as with other emerging fields, initial efforts have naturally focussed on the most obvious and severe cases. During this time, widely known and well accepted programs like Alcoholics Anonymous have arisen, counselling abstinence as the only appropriate goal for those addicted to alcohol.

But as awareness of alcohol addiction has grown and prevention and treatment efforts have expanded, it has become evident that by concentrating on severely dependent drinkers, we are seeing only part of the picture. There are many

others whose drinking may cause some — though not severe — problems to themselves, their family, friends or employers, but who are not physically dependent on alcohol and who do not see themselves as alcoholics. In fact, estimates put the number of problem drinkers at somewhere between three and seven times the number of severely dependent drinkers. Often these are people who, while recognizing that their drinking sometimes causes problems, are unwilling to abstain and are reluctant to enter treatment because they perceive existing treatment alternatives as unrealistic. And they may be correct: research has demonstrated that successful treatment approaches for problem drinkers differ substantially from treatments developed for those who are severely alcohol-dependent.

Are treatments geared only to abstinence missing the opportunity to help problem drinkers reduce the harm caused by their drinking? Is reduced drinking a viable option for some, or is abstinence the only answer? If a client refuses to accept abstinence as a goal, should treatment be refused? These are some of the questions being raised as efforts are made to help problem drinkers find the road to harm-reduction that suits them.

Conventional wisdom tells us that alcoholism is a progressive disease and that those with any clear evidence of alcohol problems will go on to devel-

op severe dependence on alcohol if they do not stop drinking. While it is true that severely dependent drinkers were at one point less severe drinkers, it does not necessarily follow that all less severe drinkers will eventually become severely dependent. Research on progression indicates that only a minority of people who experience drinking problems will have equally or more serious problems at a later point if they continue to drink. It is more typical to have periods of problems of varying severity along with periods of abstinence or nonproblem drinking.

Some would argue that those who do not progress to more and more severe problems are therefore not alcoholics, and are somehow different from true alcoholics. The problem then becomes one of either separating the true alcoholics from the problem drinkers, or of developing a treatment which suits both groups.

## Treatment approaches for severely dependent drinkers

One widely accepted view is that drinkers who have had a long career of very heavy drinking, where drinking has come to be a pervasive and integral part of their lifestyle, are generally unsuccessful and perhaps incapable of achieving a stable pattern of moderate drinking. Typically they

have suffered serious physical, social, economic and vocational consequences of their drinking, and are likely to view their lives as out of control on many levels. They are often significantly physically dependent and experience symptoms of withdrawal when they stop drinking.

For these drinkers, abstinence is clearly the appropriate treatment goal. For them, the potential risk of a renewed drinking pattern outweighs any perceived advantages of continued drinking. Given the extreme level of social and economic disruption likely to be found with these clients, it is also essential to consider re-establishing the client's social support networks as a component of treatment.

But what if such a client is unwilling to accept abstinence as a treatment goal? It has been suggested that in such cases, a reduction in drinking with the objective of harm reduction might be an appropriate interim approach, or as one researcher expressed it, "a possible backdoor to abstinence." In cases where reduced drinking is adopted as a treatment objective for severely dependent drinkers, specific goals and close monitoring are essential. If these goals are not met, then the objective of abstinence should be more strongly proposed to the client.

## Treatment approaches for problem drinkers

Problem drinkers are defined as those who are not physically dependent on alcohol, but who have experienced some — though not severe — personal, work or legal problems as a result of their drinking. Generally, their social networks are still largely intact: they hold down jobs and have stable family and social relationships.

Studies have shown that while such drinkers may recognize that their drinking is causing problems and that they could benefit from modifying their drinking practices, they are wary of being labelled alcoholics, and do not perceive current treatment options as being suited to their needs.

They are often unwilling to enter into residential programs because of the disruption to work and social life. Because they have not experienced losses to the same degree as severely dependent drinkers, and because they see their lives as being largely under their control, problem drinkers often refuse to accept so drastic a treatment goal as abstinence. One study participant expressed this point of view by saying that the problems caused by his drinking did not warrant the social cost and effort required to abstain.

Is reduced drinking an appropriate treatment goal for problem drinkers? Studies indicate that problem drinkers can successfully moderate their drinking, and in fact, even when presented with the goal of abstinence, will often end up self-moderating rather than abstaining. In studies of problem drinkers randomly assigned to no-choice abstinence goals versus drinkers permitted to choose abstinence or moderation, the end result was the same: 70 per cent of each group eventually became successful moderate drinkers. However, because members of the choice group were trained and supported in their goal of moderation, they required less aftercare than the no-choice group, who were left to develop their own moderation strategies.

The Addiction Research Foundation believes that unless there are physical, emotional or social contra-indications, reduced drinking is a supportable treatment option for problem drinkers who are unwilling to accept abstinence as a lifelong goal. Of course, since the best way to avoid drinking problems is not to drink at all, problem drinkers who wish to be abstinent should be strongly supported in that objective.

## Recommendations

Consistent with the shift in emphasis in health care from crisis care to prevention and early intervention, it is essential that the personal, social and economic costs associated with all levels of alcohol problems be addressed. While for severely dependent drinkers moderation is not an appropriate treatment goal, there are many more problem drinkers for whom it is appropriate, and goals should be set on a case-by-case basis.

The Addiction Research Foundation recommends the following as an appropriate treatment paradigm for clients with alcohol problems:

• The Foundation strongly advocates that total abstinence is the appropriate treatment goal for persons with severe alcohol problems.

This group includes those who exhibit severe levels of physical dependence, those who exhibit severe levels of alcohol-related damage, or those whose use of alcohol has repeatedly led to serious personal, financial, legal or employment problems.

Those with serious alcohol problems who refuse to accept abstinence still require treatment. In these circumstances, the negotiation of treatment plans that will reduce the severity of damage are preferable to withholding treatment.

• The Foundation advocates that unless there are physical, emotional or social contra-indications, reduced drinking is a supportable option for problem drinkers who are unwilling to accept abstinence as a lifelong goal.

The decision as to whether a client is an appropriate candidate for the goal of reduced drinking is a matter of clinical judgement, and must be made on the basis of comprehensive medical and psychosocial assessment procedures. Systematic assessment is essential in establishing the severity of a client's alcohol problem and in deciding upon the most appropriate long-term goal.

While based on an assessment of the particular circumstances of the client, clinical advice will always be based on probabilities and not certainties. Thus, for instance, advice to abstain is not based on a certain knowledge that a particular client's efforts to drink without problems will always fail, but rather on an assessment of the rates of success or failure experienced by those with similar problems.

It is also crucial that there be ongoing monitoring of a client's progress to ensure that treatment goals are achieved.

**Chapter 3**

# Substance Use and Reproduction: risks, rights and responsibilities

We have become increasingly aware that using alcohol, tobacco and other drugs can have a profound effect on the reproductive process from conception through birth. And while much of the physical and mental damage caused is irreversible, it is preventable, adding the issues of parents' rights and responsibilities to any discussion of substance use and healthy babies.

These problems are not new. We know, for example, that Fetal Alcohol Syndrome (FAS), today diagnosed as a common pattern of birth defects in children born to women who abuse alcohol, has existed for centuries. The first study showing an effect of tobacco on the developing fetus was published 50 years ago.

In more recent years the effects of alcohol and drug use during pregnancy have captured public attention, fuelled by reports of an epidemic of "crack babies," incidents in which pregnant women have been refused service in bars and even court cases prosecuting women for drug use during pregnancy.

In all of this, responsibility for a healthy pregnancy is largely seen as the woman's. Yet to address the problems associated with substance use and reproduction effectively, underlying socioeconomic issues must also be examined. The effects of poverty, lifestyle and lack of emotional support are often as important as the effects of the drug use itself.

In that context, it becomes increasingly clear that the responsibility for healthy babies does not just belong to mothers or their doctors. It is the responsibility also of fathers, of family members and friends, and of society in general.

There is still much that is not known. How common is the problem? How does the damage to the fetus occur? How often does the damage originate with the sperm? How does the male's alcohol and other drug consumption affect his pregnant partner's lifestyle? How does society balance the rights of the fetus against the rights of the woman? Does society concern itself as much with what happens to these infants after birth as it does with what happens before birth?

These questions are not fully answered by current research. Yet the area of reproduction and substance use is an example of an issue where policy and professional advice must be given on the basis of only partial knowledge. The importance of

the issue requires that the best possible advice be made available.

## What is known?

Alcohol: Birth defects associated with FAS include growth deficiencies, small heads and facial deformities. Many FAS infants are mildly or moderately developmentally disabled with little chance of improved ability to develop as they mature. And, unlike infants exposed to opiates and perhaps cocaine, FAS infants are unlikely to "catch up" in terms of physical growth.

The term Fetal Alcohol Effects, or FAE, refers to the more subtle consequences of alcohol consumption during pregnancy – low birth weight, physical defects, hyperactivity and learning and motor disabilities. Some U.S. studies show FAE is three times as prevalent as FAS, although these figures are not altogether reliable as the diagnosis itself is somewhat imprecise.

Few Canadian figures are available, but the prevalence of fetal damage is assumed to be similar to that in the United States, with higher rates among some aboriginal groups than among the general population. Recent U.S. estimates from Ernest L. Abel and Robert J. Sokol indicate that the incidence of FAS is one case per 3,000 live births.

They estimate the range from 0 to 1.58 per 1,000, depending on ethnic background and socio-economic status. In Canada, a study of children with physical or learning problems in Northern British Columbia and the Yukon indicated that 30 per cent, most of whom were native, could be categorized as having FAS or FAE.

Illicit drugs: As with alcohol, many factors complicate the effects of drug exposure on infants. General health, nutrition, housing and income all have effects on the mother and the newborn. A Canadian study of heroin-addicted mothers found that tobacco and alcohol abuse as well as poor maternal nutrition were contributing factors to low birth weight in 37 per cent of the infants. The same factors apply to the postnatal development of such babies.

The plight of "crack babies" has been particularly sensationalized by reports that such babies are permanently brain-damaged and almost impossible to care for. In fact, most researchers agree that despite some damage, the prognosis is hopeful for such children provided they receive attentive care and nurturing. It is the home and social environment, not the drugs to which the child has been exposed, which play the biggest role in the child's postnatal development. The authors of a recent study which found that studies on cocaine-exposed infants have often overesti-

mated the damage conclude that "whatever the damage from prenatal exposure to cocaine may prove to be, outcome will not be improved by an attitude that assumes that exposed children cannot be helped or that they are different from other children."

Tobacco: A number of studies of the long-term effects of tobacco use during pregnancy show an increased chance of sudden infant death syndrome, prolonged growth retardation, a slight but significant reduction in skills, like reading, and an increased incidence of hyperactivity. One Canadian study, for example, found that smoking during pregnancy reduced birth weight by 13 grams per cigarette smoked daily. Low birth weight is associated with a higher rate of infant health problems and death. A Montreal study which looked at spontaneous abortion found that there were clear and statistically significant associations with cigarette and alcohol consumption. There was a weaker but still statistically significant association with coffee consumption as well.

## The cost of substance abuse

Because so little is known of the long-term effects of substance abuse, the cost to our health care, social and education systems is difficult to measure. One attempt has been made in a 1990

report commissioned by the British Columbia Ministry of Health which estimated that the lifetime care costs for FAS children born in the province in any one year is approximately $500 million. Abel and Sokol estimate the annual cost of FAS in the United States to be $ 74.6 million annually. There is even less information about long term care costs for infants exposed to illicit drugs.

## Reducing the risk

Most of the fetal damage caused by substance abuse happens during the first trimester. In the case of FAS, women usually drank at least six standard drinks per day throughout the first trimester. There is no known safe level of alcohol consumption in pregnancy and, as a result, many authorities recommend complete abstinence. A less conservative recommendation from the Society of Obstetricians and Gynecologists of Canada recommends abstinence or a consumption level of less than four drinks per week. These drinks should be spaced out over several occasions.

Stopping the use of tobacco or illicit drugs early in pregnancy can also have significant benefits to the fetus. Ending cocaine use, for instance, by the end of the first trimester lowers the rate of prematurity and miscarriage as well as forestalling growth retardation. Women who quit using tobacco at

any time up to the 30th week of gestation have infants with higher birth weight than women who smoke throughout pregnancy. Those who quit smoking before becoming pregnant have infants of the same birth weight as women who never smoked. On the other hand, reducing daily consumption instead of quitting has little or no effect on birth weight.

## Barriers to change

There are many barriers to changing behaviour. One of the most significant is the reluctance of some who are heavy users of illicit drugs or alcohol to seek treatment. These women are understandably afraid that their children may be placed in foster care and that they may never get them back. When a pregnant woman is willing to enter treatment, she may find it difficult to manage the logistics if she already has other children.

Poverty is, in itself, a barrier to good health care. One study showed that poorer women who drank heavily were more likely to have children with FAS than more affluent women who drank heavily. The poorer mothers had poorer health conditions in general, limited access to health care and poorer diets. All of these are important to the health of a newborn and may be as telling as alcohol in the prognosis. Moreover, health professionals

may be more likely to apply the label "FAS" to infants of poor women than to infants of middle-class women.

Barriers can also be more subtle. At present, responsibility for a healthy pregnancy is largely seen as the pregnant woman's. Yet, men play an important but often invisible role in reinforcing appropriate and inappropriate drinking by their female partners. As well, there are indications that sperm damage due to the man's alcohol and drug use may contribute to damaged infants. Men and women together are responsible for setting and reinforcing expectations about appropriate drinking, including abstinence. These expectations can be expressed as personal choice, by the behaviours a society tolerates and in public policy.

## General Guidelines for Clinicians

Physicians can play a key role in reducing the risks associated with drug use during pregnancy. For a patient who sees her doctor early in pregnancy and who is motivated to change her drug use, a single counselling session may be all that is necessary. Women who are heavy drug or alcohol users but whose lives are socially stable can also be helped by their physician with a tailored detoxification schedule and weekly or biweekly counselling. If the patient is severely drug dependent

and in crisis, she should be referred to a specialized alcohol and drug treatment service.

The initial approach to a woman with a significant alcohol or drug problem should include a complete medical and obstetrical assessment. This should be done in a nonjudgmental manner. Alcohol, tobacco, caffeine, over-the-counter drugs, prescription medications and illicit substance use should each be asked about. The physical examination should screen for associated medical problems and be repeated regularly throughout the pregnancy. This procedure may have therapeutic benefits as well by helping the woman increase her commitment to a healthy pregnancy.

Women with a long history of alcohol- and drug-related problems will usually require inpatient detoxification or, in the case of heroin use, methadone treatment. Prenatal care should be integrated with treatment. If a spouse or partner is involved who also has a drug problem, he should be actively encouraged to seek treatment as well. After the birth, the progress of the mother and child should be closely followed. Postnatal care should include supportive counselling, contraception counselling, visits from a public health nurse and training in parenting skills.

Finally, many women are inadvertently exposed to medications or use alcohol, tobacco and other drugs before finding out they are pregnant. It does not necessarily follow that there is a high risk of damage to the fetus. It is not known how many women have abortions because of the fear that the fetus has somehow been harmed, but workers at Toronto's Motherisk Clinic say it is not uncommon. Physicians can direct anxious parents to expert counsellors so that an informed decision can be made.

## Public health strategies

With varying degrees of effectiveness, a range of public health strategies have been proposed in many jurisdictions to reduce the risks of substance abuse to the fetus. The debate over adopting the measure may be as important in creating public knowledge and opinion as the measure itself. These measures include:

***Warning labels*** In Canada, cigarette packages already carry a range of warning labels, including one that refers to fetal damage. Health and Welfare Canada is considering a pilot project to investigate the impact of labels about birth defects for beverage alcohol as well. Recent surveys show overwhelming support among

Canadians for a range of warning labels on beer, wine and liquor bottles.

U.S. law already requires all containers of alcoholic beverages bottled after November 1989 to include a warning about the risk of birth defects. Public support for these warnings began at 79 per cent and grew to 88 per cent after they were introduced in 1989. Studies showed that there was a strong awareness of the warnings only six months after they were introduced. One study showed that the warnings were followed by an increase in the percentage of women of childbearing age who reduced their drinking because of health concerns – from 18 per cent in 1989 to 25 per cent in 1990.

***Warning signs*** In British Columbia, warnings about FAS are posted anywhere alcoholic beverages are served. In Toronto, the City Council adopted a resolution in December 1992 instructing the City Solicitor "to draft a by-law requiring the proprietors of all premises licensed to sell alcoholic beverages in the City of Toronto to post a sign warning: 'Drinking alcoholic beverages during pregnancy can harm the baby.'" "Second-hand smoke" signs are posted in some public areas like restaurants. Several U.S. states now require that warnings about FAS be posted in all bars and restaurants.

***Treatment services*** A report by the U.S. General Accounting Office to the Senate, declaring "an urgent national response is necessary," recommended the establishment of accessible outreach services, comprehensive drug treatment and prenatal care targeted specifically to pregnant women who abuse drugs. The same report also recommended legislation requiring states to include substance-abuse treatment as one of the services available to pregnant women.

***Public education*** In Canada, the Minister of Health recently announced that Health and Welfare Canada will produce more information material on FAS and FAE for parents, teachers, medical practitioners and legislators. In the United States, a national survey showed high public awareness of the dangers associated with drinking – 84 per cent of respondents in this survey. However, a much smaller proportion were knowledgeable about FAS. In fact, another survey showed that many pregnant women and their husbands consistently expressed belief that FAS meant giving birth to a "drunk" baby who could "dry out."

## Recommendations

Most women will do everything they can to ensure that their babies have a healthy start in life.

However, for many, the resources do not exist to have a healthy pregnancy or to learn the necessary parenting skills after the child is born. A comprehensive public health approach which addresses these issues is likely to be much more effective than measures directed at the individual. We believe that public policy at all levels should address the range of society's problems with alcohol and other drugs. As well, concerns for healthy babies should be reflected in easy access to advice and support for pregnant women in the areas of nutrition, pre- and post- natal health and parenting. We recommend that:

• alcohol and drug addiction treatment services should be prepared to meet the needs of pregnant women, including transportation and daycare;

• warning signs and labels should not refer only to pregnant women but should address other alcohol, tobacco and drug problems, e.g. drinking and driving, domestic violence and other health related problems;

• physicians should advise pregnant women about alcohol consumption, emphasizing that when it comes to pregnancy, "less is better and none is best." Physicians should also raise the issues of tobacco and other drug use.


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